EMERGENCY / GENERAL ASSISTANCE PROGRAM FY'02/03

POLICY:

The Emergency Assistance Program, funded by the Tribal Council and administrated by the Division of Human Services is a program to help tribal members in **dire emergency** situations. In order to meet eligibility requirements to receive monies from this program you must meet the following criteria. ***Assistance is not to exceed two (2) times per year for medical or fire.***

☐ **MEDICAL**

Emergency Medical Assistance will be granted in dire emergencies only. A dire emergency situation is when a patient is transported by air or ambulance to a medical facility and requires an overnight stay**. All emergencies will be verified by the Human Services department.** All other medical situations will be handled by K'IMA:W Medical Center.

☐ **FIRE**

If a fire has destroyed a tribal member's home and its contents, they are eligible for assistance**. A copy of the fire report signed by the Fire Department must be attached to this application**. Assistance in any amount not to exceed $1000.00 will be paid to the head of household.

☐ **DEATH**

The Tribal Council currently has a burial fund for tribal members, which allows for funeral expenses up to $4500.00. The Emergency Assistance Program could allow an additional amount not to exceed $300.00 to **one** immediate family member that is head of household or in charge of funeral arrangements. Documentation for the expense must be submitted with the application for assistance.

☐ **ELDERLY & DISABLED**

It is a known fact that the elderly or disabled require more medical needs, prescription costs, transportation, etc. **An Elder is considered to be at least 62 years of age. All disabilities must be in accordance with the State Disability guidelines or the Social Security Administration guidelines**. Since most of the elderly are on a fixed income their medical needs impact on life support of food, energy, water and home maintenance, an amount not to exceed $300.00 may be granted. If requesting an In Home Healthcare Provider, Division of Human Services will pay a licensed In-Home Healthcare Provider for a temporary time period, not to exceed 3 weeks. **Receipts must be presented with the application for assistance.**

Name:_____ Phone #: _____

Address:_____ Message Phone:_____

Monthly Income: $_____ Source of Income:_____ # in Household:_____

Briefly describe emergency situation:

_____
_____
_____
_____
_____
_____
_____

I hereby give my consent for the Division of Human Services staff to verify any of the information and documentation I have submitted. I understand that my assistance will be based according to the given eligibility requirements and that my application will be reviewed for approval when all required written documentation has been received by the Division of Human Services.

_____ _____

Signature of Applicant Date